Child Fatality Report

Report Identification Number: NY-20-072

Prepared by: New York City Regional Office

Issue Date: Dec 31, 2020

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☒ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 28 day(s)
Jurisdiction: New York
Gender: Female
Date of Death: 07/25/2020
Initial Date OCFS Notified: 07/25/2020

Presenting Information

The report alleged on the morning of 7/25/20, the SF woke up and checked the SC in an unknown sleeping area of the home. The whereabouts of the SM at the time was unknown. The SF found the SC unresponsive and Emergency Services were called at 10:48 AM. Emergency services arrived and performed CPR. The SC was then transported to the local hospital and pronounced dead upon arrival. The SC was a healthy CH and the SM and SF provided no explanation therefore both parents were listed as alleged subjects.

Executive Summary

The 4-week-old female child (SC) died on 7/25/20. As of 12/31/20, NYCRO had not yet received a copy of the autopsy report.

At the time of the SC's death, the family had an open investigation that began on 7/18/20. On 7/25/20, the SCR registered a report that included the allegations of DOA/Fatality and IG of the SC by the SM and SF.

ACS investigative findings showed on the night of 7/24/20, the SM was at the home of the MGM. The SM arrived home with the SF and SC during the morning on 7/25/20 and the SC was crying. The SM asked the SF to hold the SC while she prepared the SC's formula. The SM then took the SC and fed and burped her. The SM was tired and falling asleep, and she attempted to wake the SF several times. The SF took the SC while lying on the bed, and the SM went to the other side of the bed to sleep. The SM believed the SF would remain awake with the SC. The SF woke the SM stating the SC was not moving and called 911. The SM said she was informed of safe sleep practices and she was told to place the SC in the crib.

According to the SF, he and the SM were out during the night of 7/24/20. He was out with friends and he used marijuana with them. He then picked up the SM and SC and they returned home. He reported being tired and falling asleep while the SM was with the SC. The SM asked him to hold the SC while she made milk. He did not recall waking a second time as the SM told him she woke him a second time when he took the SC into the bed to sleep. The SM slept on the side of the bed near the wall. The SF was in the middle and the SC was on the outer edge of the bed. The SF said he slept facing the edge of the bed and when he awoke close to 11:00 AM, he faced the wall where the SM was sleeping. He observed the SC who had one arm up stiff while the other arm was down, and blood came from the SC's nose. The SC was unresponsive, and he woke the SM.

On 7/27/20, the ME's office said preliminary findings showed there were no fatal injuries and the SC seemed to have had a normal development. An injury was observed on the forehead, but it was several days old and in the healing stages. The injury was not the cause of the SC's death and was classified as a non-acute injury. Bloody fluid was found in the airway, but this was normal. Later, the ME's office said there were no concerning injuries and no indication of diseases. The test results were pending.

On 8/11/20, a conference occurred. On 8/17/20, a clinical consultation occurred. The recommendation was the SM continue to attend her therapeutic services, and the SF to receive supportive counseling.

On 10/27/20, ACS Sub the allegations of DOA/Fatality and IG of the SC by the SM and SF. The SC died while the SM and SF were co-sleeping with the SC. The SM and SF did not put the SC in her crib and as a result she died. The ME's

office preliminary findings showed no fatal injuries. The SM was aware of the dangers of co-sleeping and left the SC on the bed. The SF caused harm to the SC and as a result the SC died.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
NA

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
A preventive services case was opened on 8/5/20 and it was closed on 10/29/20.

Required Actions Related to the Fatality

Are there Required Actions related to the compliance issue(s)? ☒Yes ☐No

Issue:	Adequacy of services following the fatality
Summary:	The 7/25/20 fatality investigation did not reflect that ACS offered burial assistance to the family.
Legal Reference:	18 NYCRR 432.2(b)(4);428.6
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/25/2020 **Time of Death:** 11:18 AM

Time of fatal incident, if different than time of death: 10:30 AM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 10:48 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

- ☒ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☐ Other

Did child have supervision at time of incident leading to death? Yes
At time of incident supervisor was: Not impaired.

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	28 Day(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	23 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	16 Year(s)

LDSS Response

On 7/25/20, LE said the SC sustained a bruise on the left chest and arm that was caused from the chest compression. An old scratch was also observed on the SC's forehead and a laceration, which was a couple of days old was observed on her right eye. The SM and SF reported they were co-sleeping with the SC. The SF was in the middle of the bed and the SC and SM were laying facing the wall. The SF awoke and felt the SC was not moving. He woke the SM and then he called 911. LE said the SM stated she and the SC were at the MGM's home preparing for a party. They arrived home and the SF went to bed. The SM warmed a bottle and she woke the SF to hold the SC while she got the bottle. The SM fed and burped the SC, woke the SF and gave him the SC and the she (the SM) was asleep until about 10:40 AM, when the SF woke the SM informing her the SC was unresponsive.

On 7/25/20, the PGF reported he was not with the family at the time the incident occurred. He said he contacted the SF who said they fed the SC and laid her down. They were tired and when the SF woke the SC was not breathing.

On 7/25/20, the SM said the SF held the SC while lying on the bed and she went to the other side of the bed to sleep. The SM believed the SF would remain awake with the SC. The SF woke her stating the SC was not moving and called 911.

The SM said the SC was crying and the only way she would stop was being held or in the bed. The SM denied substance abuse. Later, the SM said when they arrived home, the SC was crying. The SM gave the SF the SC as she made a bottle. The SM fed and burped the SC and when finished, she returned the SC to the SF. The SM said she was tired, and the SF had the SC next to him so, she laid in the bed and fell asleep. The SM said she did not place the SC in the crib as she was tired, and did not want to wake the SC.

The SF said he slept facing the edge of the bed and when he awoke close to 11:00 AM, he faced the wall where the SM was sleeping. He observed the SC who had one arm up stiff while the other arm was down, and blood flowed from the SC's nose. The SC was not responsive, and he woke the SM, and called 911. The SF said he used marijuana but did not provide details. Later, he said the SC slept during the car ride but when they arrived home the SC cried. The SM told him to supervise the SC, so he put her to lay next to him, but he fell asleep. He said the SM stated she woke him after she fed the SC, but he did not recall being awakened by the SM. He said he awoke around 10:40 AM and found the SC next to him. He went to pick her up to place her in the crib, but she was stiff and cold.

On 7/25/20, the MGM told ACS she learned of the SC's death when the SM called and said the SC asphyxiated. The SM brought the SC to her home on 7/24/20 and the SC was alert. The SF came to the home after 3:00 AM and then they returned to their home. The MGM reported the SM and SF took good care of the SC.

On 8/11/20, ACS interviewed a service provider who said the SM had been receiving therapeutic services since May 2020. The SM was consistent with her appointments, participated in sessions and made progress. The provider was concerned about the SM and MGM's relationship.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No
Comments: The case documentation did not reflect there was a MDT response.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved Child Fatality Review Team in NYC.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
055741 - Deceased Child, Female, 28 Days	055743 - Father, Male, 23 Year(s)	DOA / Fatality	Substantiated
055741 - Deceased Child, Female, 28 Days	055742 - Mother, Female, 16 Year(s)	Inadequate Guardianship	Substantiated
055741 - Deceased Child, Female, 28 Days	055742 - Mother, Female, 16 Year(s)	DOA / Fatality	Substantiated
055741 - Deceased Child, Female, 28 Days	055743 - Father, Male, 23 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☐	☒	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☒	☐	☐	☐

Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☐	☐	☐	☒	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? N/A
Explain:
There were no SSs and no other CH residing in the home.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The documentation reflected ACS provided a referral for bereavement to the SF. The SF was provided with information for counseling.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? N/A
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

☐ Had medical complications / infections
☐ Misused over-the-counter or prescription drugs
☐ Had heavy alcohol use
☐ Smoked tobacco

☐ Experienced domestic violence
☐ Used illicit drugs
☒ Was not noted in the case record to have any of the issues listed

Infant was born:
☐ Drug exposed
☐ With fetal alcohol effects or syndrome
☒ With neither of the issues listed noted in case record

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/18/2020	Deceased Child, Female, 21 Days	Mother, Female, 16 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Female, 21 Days	Mother, Female, 16 Years	Lack of Supervision	Substantiated	

Report Summary:
On 7/18/20, the SC sustained open abrasions to her right forehead. The explanation given by the SM was inconsistent with the injury; therefore it was considered suspicious. The role of the SF was unknown.

Report Determination: Indicated
Date of Determination: 09/16/2020

Basis for Determination:
The SM left the SC on their bed unsupervised and as a result the SC fell and sustained a cut and bruise on her forehead. The SM placed the SC at risk and as a result harm was caused. The SM did not provide adequate supervision of the SC which resulted in her being harmed. The SM did not provide the SC with food, clothes, and medical care. The SM's decision to leave the SC on the bed instead of placing her in the crib resulted in the SC being harmed.

OCFS Review Results:
The Dr. said the SC sustained a laceration with bleeding when, according to the SM, the SC rolled/fell off the bed when she went to prepare a bottle. The Dr. said although uncommon for newborn infants to maneuver themselves off a bed, the SC was wiggly and active. The Dr. did not suspect abuse or that the injury was inflicted. The SM said she was in and out of the room and she was preparing a bottle for the SC. The SM heard a thump and the SC hit the floor. The SC was on the bed. LE said the SM's account was consistent with the injury. No arrest was made.

Are there Required Actions related to the compliance issue(s)? ☒Yes ☐No

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:
The progress notes were not entered contemporaneously. An event occurred on 7/21/20 but was not entered until 9/16/20.

Legal Reference:
18 NYCRR 428.5

Action:
ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

CPS - Investigative History More Than Three Years Prior to the Fatality

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS History outside of NYS.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No